CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Division of Policy and Operations

(Amended After Comments)

907 KAR 8:015. Independent occupational therapy service reimbursement provisions and requirements.

RELATES TO: KRS 205.520

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 42 C.F.R. 440.130, 42 U.S.C. 1396d(a)(13)(C)

NECESSITY, FUNCTION, AND CONFORMITY: The Cabinet for Health and Family Services, Department for Medicaid Services, has a responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed or opportunity presented by federal law to qualify for federal Medicaid funds. This administrative regulation establishes the Department for Medicaid Services' reimbursement provisions and requirements regarding occupational therapy services provided by an independent occupational therapist, or an occupational therapy assistant working under the direct supervision of an independent occupational therapist, to Medicaid recipients who are not enrolled with a managed care organization.

Section 1. General Requirements. (1) For the department to reimburse for an occupational therapy service under this administrative regulation, the:

(a) Occupational therapist shall meet the provider requirements established in 907 KAR 8:010; and

(b) Service shall meet the coverage and related requirements established in 907 KAR 8:010.

(2) Occupational therapy services provided in accordance with 907 KAR 8:010 and by an occupational therapy assistant who works under the direct supervision of an occupational therapist who meets the requirements in 907 KAR 8:010 shall be reimbursable if the occupational therapist is the biller for the therapy.

Section 2. Reimbursement. **(1)** The department shall reimburse for an occupational therapy service provided by an:

(a)[~~(1)~~] Occupational therapist, in accordance with 907 KAR 8:010 and Section 2 of this administrative regulation, at 63.75 percent of the rate for the service listed on the **current** Kentucky-specific Medicare Physician Fee Schedule; or

(b)[~~(2)~~] Occupational therapy assistant working for an occupational therapist, in accordance with 907 KAR 8:010 and Section 2 of this administrative regulation, at 37.5 percent of the rate for the service listed on the **current** Kentucky-specific Medicare Physician Fee Schedule.

(2)(a) The current Kentucky-specific Medicare Physician Fee Schedule shall be the Kentucky-specific Medicare Physician Fee Schedule used by the Centers for Medicare and Medicaid Services on the date that the service is provided.

(b) For example, if an occupational therapy service is provided on a date when the Centers for Medicare and Medicaid Services':

1. Interim Kentucky-specific Medicare Physician Fee Schedule for a given year

is in effect, the reimbursement for the service shall be the amount established on the interim Kentucky-specific Medicare Physician Fee Schedule for the year; or

2. Final Kentucky-specific Medicare Physician Fee Schedule for a given year is in effect, the reimbursement for the service shall be the amount established on the final Kentucky-specific Medicare Physician Fee Schedule for the year.

Section 3. Not Applicable to Managed Care Organizations. A managed care organization shall not be required to reimburse in accordance with this administrative regulation for a service covered pursuant to:

(1) 907 KAR 8:010; and

(2) This administrative regulation.

Section 4. Federal Approval and Federal Financial Participation. The department's reimbursement for services pursuant to this administrative regulation shall be contingent upon:

(1) Receipt of federal financial participation for the reimbursement; and

(2) Centers for Medicare and Medicaid Services' approval for the reimbursement.

Section 5. Appeals. A provider may appeal an action by the department as established in 907 KAR 1:671.

907 KAR 8:015

REVIEWED:

Date

Lawrence Kissner, Commissioner
Department for Medicaid Services

APPROVED:

Date

Audrey Tayse Haynes, Secretary
Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS AND TIERING STATEMENT

Administrative Regulation: 907 KAR 8:015
Contact: Stuart Owen

(1) Provide a brief summary of:

(a) What this administrative regulation does: This is a new administrative regulation which establishes the Department for Medicaid Services' reimbursement provisions and requirements regarding occupational therapy services provided by an independently enrolled occupational therapists, or occupational therapy assistant working under the direct supervision of an independently enrolled occupational therapist, to Medicaid recipients who are not enrolled with a managed care organization. Managed care organizations are not required to reimburse for occupational therapy services pursuant to this administrative regulation. Currently, the Department for Medicaid Services (DMS) covers occupational therapy services when provided in a physician's office (and the physician is the billing entity), when provided as a home health service (billed by a home health agency), when provided in a nursing facility as an ancillary service, when provided in an intermediate care facility for individuals with an intellectual disability as an ancillary service, or in a 1915(c) home and community based waiver program. This administrative regulation authorizes occupational therapists to enroll as independent Medicaid providers, rather than work for or under contract with, one (1) of the aforementioned provider types and be reimbursed for occupational therapy services provided to Medicaid recipients. DMS is expanding the occupational therapy service provider base in concert with expanding the Medicaid eligibility groups authorized or mandated by the Affordable Care Act. The Affordable Care Act created a new eligibility group, mandated for all states, comprised of former foster care individuals between the ages of nineteen (19) and twenty-six (26) who aged out of foster care while receiving Medicaid coverage. Additionally, the Affordable Care Act authorized states to add an eligibility group known as the "expansion group." The expansion group is comprised of adults under sixty-five (65), who are not pregnant, who have income below 133 percent of the federal poverty level, and who do not otherwise qualify for Medicaid benefits. DMS must expand its provider base to meet the demand of the additional Medicaid recipients DMS anticipates beginning January 1, 2014 (in order to ensure recipient access to care.) This administrative regulation is being promulgated in conjunction with two (2) other administrative regulations necessary to implement this initiative – 907 KAR 8:010, Independent occupational therapy service coverage provisions and requirements and 907 KAR 8:005, Definitions for KAR Chapter 8.

(b) The necessity of this administrative regulation: This administrative regulation is necessary to expand the Medicaid base of occupational therapy service providers in order to meet the demand for care (thus, to ensure recipient access to care.)

(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of the authorizing statutes by enabling the Department for Medicaid Services to meet the requirement of ensuring recipient access to care.

(d) How this administrative regulation currently assists or will assist in the effective

administration of the statutes: This administrative regulation will assist in the effective administration of the authorizing statutes by enabling the Department for Medicaid Services to meet to meet the requirement of ensuring recipient access to care.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:

(a) How the amendment will change this existing administrative regulation: The amendment after comments clarifies that DMS will use the version of the Kentucky-specific Medicare Physician Fee Schedule used by the Centers for Medicare and Medicaid Services (CMS) at the time that the service is provided. CMS uses an interim fee schedule initially during a given year and then adopts a final version later in the year.

(b) The necessity of the amendment to this administrative regulation: The amendment after comments is necessary to clarify that DMS will use the current (whether interim or final for a given year) Kentucky-specific Medicare Physician Fee Schedule used by the Centers for Medicare and Medicaid Services.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment after comments conforms to the content of the authorizing statutes by clarifying policy.

(d) How the amendment will assist in the effective administration of the statutes: The amendment after comments assists in the effective administration of the authorizing statutes by clarifying policy.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Any occupational therapist licensed in Kentucky may be affected if the individual wishes to enroll in the Medicaid Program and be reimbursed for occupational therapy services provided to Medicaid recipients. Similarly, occupational therapy assistants who wish to work for/under the supervision of an independently enrolled occupational therapist will be affected by the administrative regulation. Additionally, Medicaid recipients in need of occupational therapy services will be affected by the administrative regulation. The Department for Medicaid Services (DMS) is unable to predict how many occupational therapists will choose to enroll in the Medicaid Program, nor how many occupational therapy assistants will elect to work for/under the supervision of an independently enrolled occupational therapists, nor how many Medicaid recipients will receive services from independently enrolled occupational therapists.

(4) Provide an analysis of how the entities identified in question (3) will be impacted by either the implementation of this administrative regulation, if new, or by the change, if it is an amendment, including:

(a) List the actions that each of the regulated entities identified in question (3) will have to take to comply with this administrative regulation or amendment. An occupational therapist who wishes to provide services to Medicaid recipients will need to enroll with the Medicaid Program as prescribed in the Medicaid provider enrollment regulation (complete and application and submit it to DMS) and sign agreements with managed care organizations if the agency wishes to provide services to Medicaid recipients who are enrolled with a managed care organization.

(b) In complying with this administrative regulation or amendment, how much will it cost each of the entities identified in question (3). An occupational therapist who wishes to provide occupational therapy to Medicaid recipients could experience administrative costs associated with enrolling with the Medicaid Program.

(c) As a result of compliance, what benefits will accrue to the entities identified in question (3). An occupational therapist who enrolls with the Medicaid Program will benefit by being reimbursed for services provided to Medicaid recipients. Occupational therapy assistants will benefit from having an expanded pool of employers/employment settings in which to work. Medicaid recipients in need of occupational therapy services will benefit from an expanded base of providers from which to receive occupational therapy services.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: The Department for Medicaid Services (DMS) estimates that implementing this administrative regulation will increase DMS expenditures by $1.43 million ($271,530 state funds/$1.16 million federal funds) for state fiscal year 2014.

(b) On a continuing basis: DMS estimates that implementing this administrative regulation will cost DMS approximately $1.91 million ($362,000 state funds/$1.55 million federal funds) annually, beginning with state fiscal year 2015.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: The sources of revenue to be used for implementation and enforcement of this administrative regulation are federal funds authorized under Title XIX of the Social Security Act and matching funds of general fund appropriations.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment. Neither an increase in fees nor funding is necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor increases any fees.

(9) Tiering: Is tiering applied? Tiering is not applied as the policies apply equally to the regulated entities.

FEDERAL MANDATE ANALYSIS COMPARISON

1. Federal statute or regulation constituting the federal mandate. 42 U.S.C. 1396a(a)(30).

2. State compliance standards. KRS 205.520(3) states: "Further, it is the policy of the Commonwealth to take advantage of all federal funds that may be available for medical assistance. To qualify for federal funds the secretary for health and family services may by regulation comply with any requirement that may be imposed or opportunity that may be presented by federal law. Nothing in KRS 205.510 to 205.630 is intended to limit the secretary's power in this respect."

3. Minimum or uniform standards contained in the federal mandate. Medicaid programs are not required to cover occupational therapy services; however, each state's Medicaid program is required (for the services it does cover) to ensure recipient access to those services. As the Department for Medicaid Services (DMS) covers occupational therapy services, it must ensure that an adequate provider base exists to ensure recipient access to care. A relevant federal law – 42 U.S.C. 1396a(a)(30) requires a state's Medicaid program to "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan (including but not limited to utilization review plans as provided for in section 1903(i)(4)) as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." Creating a new base of authorized providers comports with the intent of the aforementioned federal law.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate? The administrative regulation does not impose stricter than federal requirements.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements. The administrative regulation does not impose stricter than federal requirements.

FISCAL NOTE ON STATE OR LOCAL GOVERNMENT

1. What units, parts or divisions of state or local government (including cities, counties, fire departments, or school districts) will be impacted by this administrative regulation? The Department for Medicaid Services will be affected by the amendment to this administrative regulation.

2. Identify each state or federal regulation that requires or authorizes the action taken by the administrative regulation. This administrative regulation authorizes the action taken by this administrative regulation.

3. Estimate the effect of this administrative regulation on the expenditures and revenues of a state or local government agency (including cities, counties, fire departments, or school districts) for the first full year the administrative regulation is to be in effect.

(a) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for the first year? No revenue is anticipated.

(b) How much revenue will this administrative regulation generate for the state or local government (including cities, counties, fire departments, or school districts) for subsequent years? No revenue is anticipated.

(c) How much will it cost to administer this program for the first year? The Department for Medicaid Services (DMS) estimates that implementing this administrative regulation will increase DMS expenditures by $1.43 million ($271,530 state funds/$1.16 million federal funds) for state fiscal year 2014.

(d) How much will it cost to administer this program for subsequent years? DMS estimates that implementing this administrative regulation will cost DMS approximately $1.91 million ($362,000 state funds/$1.55 million federal funds) annually, beginning with state fiscal year 2015.

Note: If specific dollar estimates cannot be determined, provide a brief narrative to explain the fiscal impact of the administrative regulation.

Revenues (+/-):

Expenditures (+/-):

Other Explanation: